Public Health Then and Now

Driving Through: Postpartum Care During World War II

ABSTRACT

In 1996, public outcry over shortened hospital stays for new mothers and their infants led to the passage of a federal law banning "drive-through deliveries." This recent round of brief postpartum stays is not unprecedented. During World War II, a baby boom overwhelmed maternity facilities in American hospitals. Hospital births became more popular and accessible as the Emergency Maternal and Infant Care program subsidized obstetric care for servicemen's wives. Although protocols before the war had called for prolonged bed rest in the puerperium, medical theory was quickly revised as crowded hospitals were forced to discharge mothers after 24 hours. To compensate for short inpatient stays, community-based services such as visiting nursing care, postnatal homes, and prenatal classes evolved to support new mothers. Fueled by rhetoric that identified maternal–child health as a critical factor in military morale, postpartum care during the war years remained comprehensive despite short hospital stays. The wartime experience offers a model of alternatives to legislation for ensuring adequate care of postpartum women. (*Am J Public Health*. 1999; 89:587–595)

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"Parents may rush to the hospital, but they shouldn't be rushed out."[1] So said President Clinton in September 1996 as he signed legislation (Pub L No. 104-204, §711) mandating insurance companies to cover the cost of inpatient postpartum care for a minimum of 48 hours after vaginal deliveries and 96 hours after cesarean deliveries. During the election year, "drive-through deliveries" became the focal point of public outcry over insurance companies' increasing power to dictate the content and duration of medical care. While the institution of prospective payment plans by Medicare and then private insurers in the mid-1980s created an economic incentive to curtail the length of stay for all types of inpatient care, the early discharge of mothers and infants uniquely captured the public's attention. Once confined to the professional literature of medicine and nursing, debates about the scope of postpartum care spread into mass culture, as on the *Oprah Winfrey Show*, where First Lady Hillary Rodham Clinton told Oprah, "I personally am appalled that we are now discharging mothers with babies as soon as we possibly can get them out the door."[2] Politicians from both parties were quick to endorse state and federal laws banning drive-through deliveries, as they offered a relatively harmless and inexpensive way to address, or appear to address, larger problems with the nation's health care system.[3]

Advocates of such legislation frequently invoked nostalgic images of a past when mothers enjoyed a leisurely recovery and hospital stays were dictated solely by a doctor's judgment and a patient's wishes.[4] Yet brief postpartum convalescences are not a new phenomenon. During World War II, a rising birth rate necessitated the rationing of hospital time and services for new mothers. This article recounts the events leading to short maternity stays during the war and examines the solutions implemented to cope with the nation's first round of drive-through deliveries.

"Now Is the Time to Have Children"

Among the slang terms that entered the popular lexicon during World War II were 2 that reflected the war's impact on American demographics: "suitcase wife" and "storker."[5] A suitcase wife was a woman who left home and moved to the town near the training camp where her husband was based, wishing to be near him for as long as possible before he was shipped overseas. Suitcase wives who were pregnant were called storkers. In fact, most suitcase wives were storkers: the birth rate, which in the late 1930s had been hovering between 18.4 and 19.2 live births per 1000 population, rose to 22.7 at the height of the wartime baby boom in 1943.[6]

Pronatalism was everywhere, including the *Ladies' Home Journal*, which informed its readers in 1942, "Now Is the Time to Have Children." Dismissing common doubts about the wisdom of bringing babies into a world at war, the article cited studies showing that "there was a regular association between size of family and happiness of parents."[7] In another *Journal* article later that year, a war bride came straight to the point about the desirability of motherhood during wartime: "The nation needs babies. And after all, we have to face the fact that our husbands might not return. I'd at least have his child to comfort my future years."[8] In a 1943 issue of *Collier's*, a writer denouncing storkers for crowding the camp towns concluded, "They haven't any sense and, biologically speaking, it's a good thing they haven't, for, thanks no little

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to their witless conduct, the birth rate is booming, as it always does in wartime and always should."[9]

It was not the booming birth rate alone that created an acute shortage of postpartum beds, but the fact that more and more mothers were delivering and recovering from childbirth in the hospital. In 1935, 35.4% of American births took place in the hospital; by 1945, that figure had increased to 78.8%.[10] Giving birth in the hospital had been gaining in popularity since the 1920s. As urbanization weakened the networks of family and friends that had traditionally aided new mothers, home births had become less feasible. Women were drawn by the hospital's scientific mystique as advances in bacteriology, surgery, and anesthesia promised to make childbirth safer and less painful. Obstetricians encouraged hospitalization for their patients because of a growing conviction, advanced by the obstetrician Joseph B. DeLee, that the potential pathology of birth was best prevented with proactive interventions, such as episiotomies and the use of forceps. Obstetricians also derived practical benefits from hospital births: convenience, efficiency, and a high-volume venue for the training of medical students.[11]

During the war, 2 economic factors further fueled the shift from home to hospital births. One was the rapid expansion of Blue Cross, which was stimulated by regulations to stabilize the booming war economy. In 1942, the Office of Economic Stabilization instituted wage controls to prevent employers from inflating wages to attract workers in the competitive marketplace. Although wages were frozen, the National War Labor Board did approve an increase in fringe benefits, including health plans. Offering health insurance was a win-win opportunity for employers to attract workers and, because health insurance was a deductible business expense, to reduce high wartime taxes on corporate profits. As a result, enrollment in Blue Cross rose from 4.4 million in 1940 to 15.7 million in 1945. Third-party coverage of maternity care made inpatient childbirth financially possible for more working and middle-class women.[12]

The second factor that directed wartime mothers into the hospital was the Emergency Maternal and Infant Care (EMIC) program, established in 1943. This federally funded program for servicemen's wives and infants represented "the largest single public maternity care measure so far undertaken in this country." While in operation in the years 1943 through 1949, EMIC covered the cost of more than 1.2 million—1 of every 7—American births.[13]

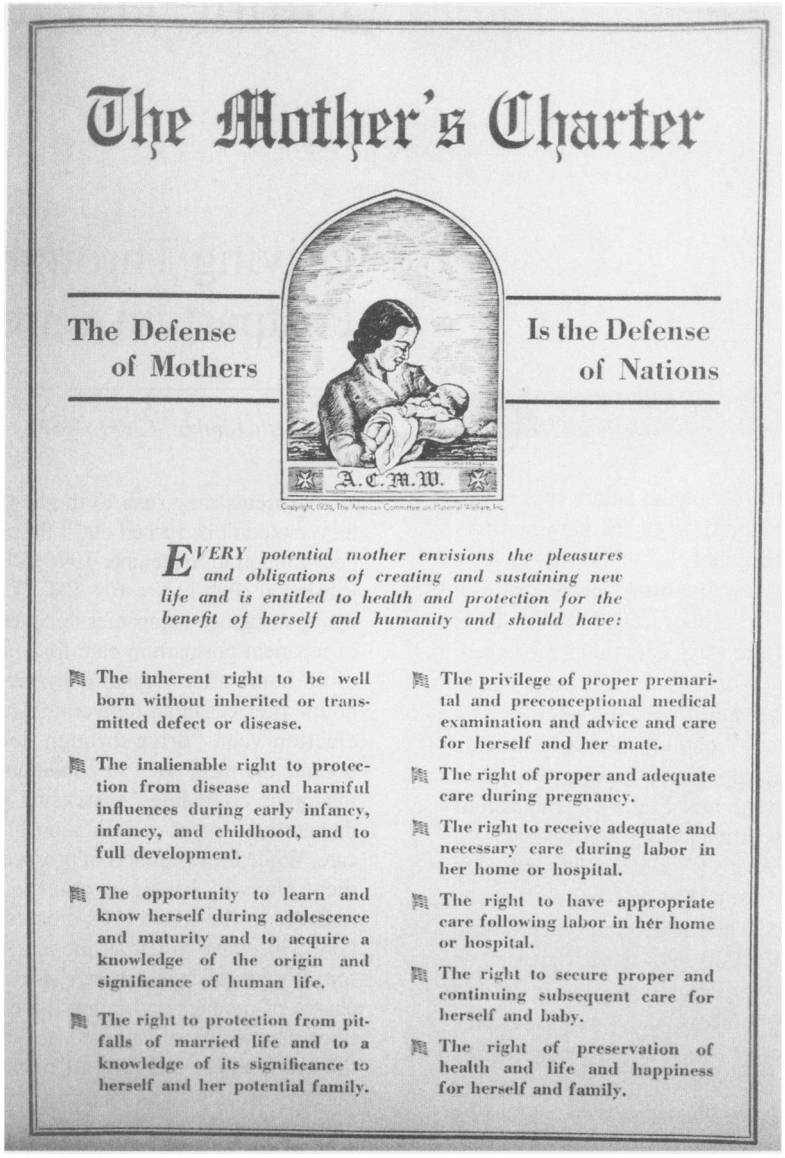


FIGURE 1—Why maternal health improves during wartime. Poster of the American Committee on Maternal Welfare, published in *Public Health Nursing* 33 (1941), 727. Reprinted with permission of Blackwell Science, Inc.

The Emergency Maternal and Infant Care Program

Wartime pronatalism served as fertile ground for the growth of a national health program for mothers and infants. In the rhetoric of the day, the family took on political significance as an integral component of national security.[14] Mothering, in particular, was portrayed as part of the war effort. A 1943 pamphlet issued by the United States Children's Bureau proclaimed the importance of homemakers' role in nurturing children and urged citizens to give mothers "community recognition for being what they are—war workers of the highest rank."[15] In this context, in which motherhood itself was patriotic, safeguarding the health of mothers and their infants acquired a new status and urgency (Figure 1). Dr. Martha M. Eliot, associate chief of the Children's Bureau, noted, "In time of war the responsibility of the government to conserve the lives of mothers and children suddenly becomes obvious."[16]

Nowhere was this need more obvious than at the draft board. More than one fourth of the 18-year-olds examined were rejected as physically or mentally unfit to serve in the military.[17] Such statistics inspired measures to ensure a cohort of healthy mothers, as the reproduction of a generation of healthy sol-

diers was seen to be as crucial as the production of weapons. A 1941 editorial in *The New York Times,* bemoaning the high rate of selective service rejections, cited the World War I defense slogan, "The health of the child is the power of the nation." The author observed that the truth of this principle had been borne out in the most unfortunate way: during World War I the slogan was dismissed as "farfetched" in light of immediate military concerns, and health care policy had gone largely ignored; now the infants of World War I had matured into the current generation of medical rejects. He called for the expansion of maternal–child health services to benefit the "recruits for 1960."[18] Savvy members of the Children's Bureau capitalized on public anxieties about the health of current and future draftees to put maternal–child health on the national agenda. As one nurse phrased it, "Mothers and babies are social priority number one. When Americans realize this, safe obstetric care will be provided as we now provide ships and tanks and planes."[19]

Among the first Americans to make mothers and babies social priority number one was a colonel in the military boomtown of Fort Lewis, Wash. In 1941, the area surrounding Fort Lewis was flooded with suitcase wives and storkers. The maternity facilities at the military hospital were filled to capacity. The colonel asked the Children's Bureau if it might be possible to organize care for the storkers under Title V of the Social Security Act of 1935, which provided federal funds to state maternal–child health programs. He told Martha Eliot, "I wasn't going to have them having their babies out there on the grass."[20] Eliot arranged to use Social Security Act funds to enable Fort Lewis storkers to get free care at the civilian hospital in nearby Tacoma.

Other states established similar maternity programs for servicemen's wives, and soon the Social Security Act funds were insufficient. Eliot requested additional money from the Congressional Bureau of the Budget, and because of the prevailing ideology linking motherhood and patriotism, she met no resistance. As one Bureau member reasoned, "There's nothing like babies and soldiers. And when you combine them, you've got something that will appeal to anybody!"[21] In 1943, Congress authorized the EMIC program, to be directed by Eliot (Figure 2). Nicknamed "the stork bill," EMIC used the administrative machinery of the Social Security Act and operated with funds appropriated to the Children's Bureau for distribution as state health grants. These grants funded maternity and pediatric care for the wives and babies of enlisted men in the 4 lowest pay grades—87% of all enlisted men.[22] Within a year, all 48 states, the District of Columbia, Alaska, Hawaii, and Puerto Rico were participating in the EMIC program. Appropriations for EMIC from 1943 to 1947 amounted to more than $130 000 000.[23]

FIGURE 2—Martha Eliot and an EMIC baby. From *American Magazine*, November 1944, 135.

EMIC accelerated the trend of hospitalization for childbirth. While EMIC funds could be used to subsidize maternity care at home or in the hospital, the vast majority of EMIC mothers gave birth and recovered as inpatients. In 1944, for example, the rate of hospitalization for all mothers was 76%, but the rate for EMIC mothers was 91%. In rural areas the impact of EMIC on hospital use was even more striking. In 1944, 30% of all births in Mississippi took place in the hospital and 70% at home. For Mississippi mothers receiving care under the EMIC program, the figures were reversed, with 70% giving birth in hospitals and 30% at home.[24] This increase in hospitalization is not surprising. The social networks that had supported childbirth and convalescence at home in an earlier era did not exist for the suitcase wives who had traveled far from their own communities. Moreover, for EMIC mothers, there were no financial barriers to hospital care (Figure 3). While opponents of "socialized medicine" complained that EMIC violated patients' rights to free choice of a physician, since not all doctors participated in the program (although all could), EMIC's advocates pointed out that "free choice is in fact made a reality. . . by the removal of economic barriers between [a patient] and a doctor."[25]

No Room at the Inn

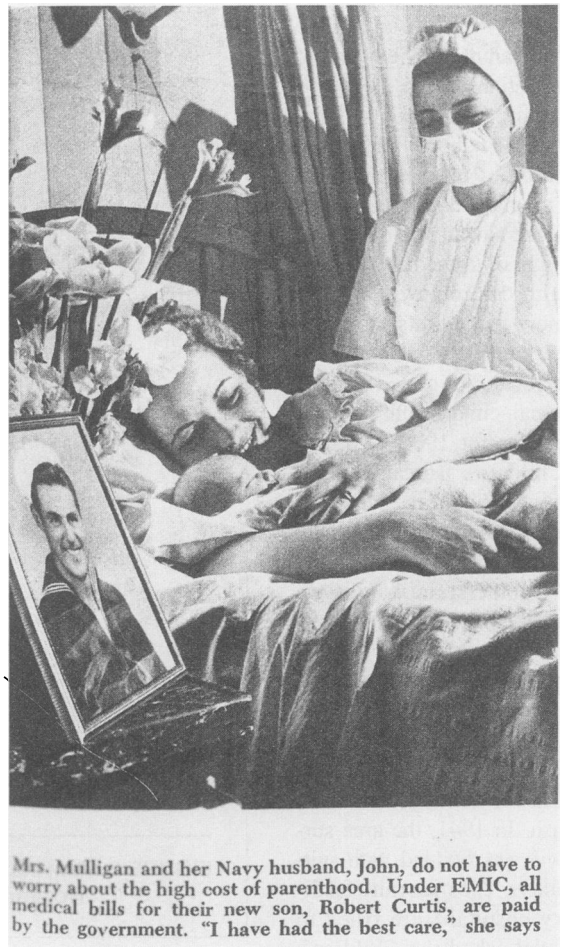
The availability of federal and private health coverage made hospital care more accessible, but there was little the Children's Bureau or Blue Cross could do to overcome the major limitation of maternity care during wartime: there were simply not enough beds for new mothers, particularly in the communities surrounding military bases and industries. One writer surveying boomtown maternity facilities declared, "Having a baby in one of the nation's war-madhouse areas is a desperate adventure second only to war itself."[26] Even in cities that were not overwhelmed by an influx of storkers, wartime prosperity led to a change in patterns of hospital use that funneled the growing demand for maternity care into a smaller pool of hospital beds. During the war, obstetrics admissions to public hospitals plummeted. *The New York Times* reported that on a Sunday during the peak of

the wartime baby boom in 1943, fewer than half of the maternity beds in New York's public hospitals were occupied. The *Times* attributed this paradox to 2 factors. First, rising wartime incomes enabled even uninsured women to afford private hospitals. (Despite wage controls, between 1938 and 1941 the average income of New York families had risen by nearly 50%.[27]) Second, EMIC mothers, who were given free choice among hospitals affiliated with the program (as more than 75% were), preferred the private institutions.[28] Private hospitals and military communities therefore bore a disproportionate share of the baby boom. Their maternity wards were forced to find ways to manage the growing patient census.

Edward Kirsch, the assistant director of the Jewish Hospital in Brooklyn, was undaunted by this task. In 1943 he published an article in *Modern Hospital* confidently titled, "There Are Ways of Balancing Obstetrical Facilities With the Rising Birth Rate."[29] Kirsch conceded that new construction was nearly impossible during wartime and suggested ways for hospitals to make the most of their postpartum units' space. First he recommended converting "luxury space" such as waiting rooms and nurses' lounges into patient rooms. Next, he advised that extra beds be moved into existing postpartum rooms, noting that " 'crowding' and 'overcrowding' are relative terms."

EMIC administrators at the Children's Bureau thought otherwise, as the program's goal was to improve not only the accessibility of maternity care but also its safety. Cognizant that the shift from home to hospital birth in the 2 preceding decades had led to an alarming increase in puerperal sepsis, the Children's Bureau required that all hospitals participating in EMIC meet minimum standards to prevent cross-infection. These standards included housing postpartum women in wards completely separated from patients with communicable diseases and providing each mother with at least 60 square feet of space.[30] Such policies (along with the increasing use of antibiotics) helped reduce maternal mortality from 31.7 per 10 000 live births in 1941 to 9.0 per 10 000 when EMIC was terminated in 1949, but they exacerbated maternity units' space problems.[31]

Kirsch also raised the possibility of home births for multiparous patients with uncomplicated pregnancies. This option, when suggested by the president of the American Hospital Association the previous year, had not impressed administrators, who pointed out that the shortage of civilian physicians and nurses made one-on-one home care even less feasible than mass care in an overcrowded hospital.[32] Except for sliding an extra bed into the nurses' lounge (the nurses were all in the army anyway), only one solution remained: early discharge.



Mrs. Mulligan and her Navy husband, John, do not have to worry about the high cost of parenthood. Under EMIC, all medical bills for their new son, Robert Curtis, are paid by the government. "I have had the best care," she says

FIGURE 3—Postpartum care from Uncle Sam. From "Babies for Free," *Collier's*, August 1945, 19.

Obstetricians of the previous 4 decades had insisted that prolonged bed rest was absolutely crucial to a safe postpartum recovery. DeLee's 1914 prescription for activity for the new mother typified medical protocols of the day: bed rest for 8 days, sitting up in bed on day 9, sitting in a rocking chair on day 10, standing on the 11th day, walking around the bedroom on the 12th, and going downstairs on the 15th.[33] Physicians advocated immobilization to prevent pressure on the pelvic organs, which was thought to precipitate pelvic vein thrombosis and subsequent emboli to the heart and lungs.[34] Few women who delivered at home had the domestic help to enable them to follow such a regimen; stories of rural women giving birth in the morning and milking the cows in the evening abounded.[35] Obstetricians reasoned that "primitive" poor women, having less-developed minds, had stronger bodies that could withstand activity after childbirth; such effort remained unsuitable for wealthier women, whose bodies had been made weak by education.[36] As hospitalization became more common in the 1930s, extended postpartum stays were the norm for urban rich and poor alike. The 1937 *Report of the Hospital Survey for New York* documented that in the city's public hospitals, physicians prescribed bed rest for an average of 8.1 days and discharged postpartum patients after 9.4 days. In private hospitals, mothers stayed in bed for an average of 9.2 days and were discharged after 11.4 days.[37]

A lengthy postpartum hospital stay was perceived to offer new mothers a chance for physical recuperation as well as a mental respite from the demands of home and family life. Recognition of the value of a postpartum "vacation" led to what was probably the first consumer outcry over shortened maternity stays. In 1930, Alameda County Hospital in Oakland, Calif, faced a shortage of maternity beds as the dismal home condi-

tions produced by the Depression prompted more and more women to give birth in hospitals. Arguing that childbirth, not recovery, was "the chief reason for obstetric hospitalization," the hospital shortened postpartum stays to 4 days. To compensate for the brief inpatient stay, new mothers received at no charge the services of both visiting nurses and visiting housekeepers (women who were employed by California's State Emergency Relief Administration, the state equivalent of the Works Progress Administration).

Despite these generous provisions for follow-up care, the program created an uproar. The hospital's early discharge policy was condemned by the county grand jury and the Institutions Committee, a citizens' group that oversaw the county's health care agencies. The hospital presented evidence that there had been no increase in puerperal complications since the early discharge program was instituted, but it was not the mothers' physical safety that concerned the grand jury. Rather, the cause for worry was the "resulting discomforts when the patient is suddenly thrust back into the turmoil" of her home environment.[38]

Despite the criticism, the early discharge program continued, and when war broke out Alameda County Hospital was cited as a model.[39] The war had already brought quick maternity care to London, where the blitz of 1940–1941 led hospitals fearful of bombings to release mothers to the safety of their own homes 2 or 3 days after giving birth.[40] Now American hospitals, "blitzed" by a baby boom, adopted a similar policy. In the face of a bed shortage, time-honored theories about the physiological necessity of prolonged rest were discarded more or less overnight. Physicians and hospital administrators advocating early discharge argued, correctly, that practices regarding the length of confinement were only medical constructs, reflecting a particular time and particular circumstances. As such, these practices could easily be changed: "The exact medical regimen of the puerperium has varied from century to century and from one social class to another. . . . With the current shortage of maternity beds. . . we have increased our maternity bed turnover by resurrecting the custom of allowing patients out of bed early in the puerperium."[41]

Actually, early discharge did not need to be resurrected so much as it needed to be legitimized. Poor women with pressing duties at home and without access to hospital care had always made do with a brief convalescence. But now that early discharge was spreading to the middle class and to mainstream medical practice, physicians sought to prove that the practice was safe. Dr Morris Rotstein at Sinai Hospital in Baltimore conducted an experiment to discover the effects of a shortened period of bed rest. Subjects in the treatment group of 150 women with normal vaginal deliveries were allowed out of bed on the third or fourth postpartum day. The control group followed the hospital's standard protocol of 10 to 12 days of bed rest. Once out of bed, mothers in the treatment group cared for themselves and also supplemented the depleted civilian nursing staff by helping to care for other patients still in bed and by packing supplies for the maternity department. Women in the treatment group exhibited accelerated uterine involution and a lower morbidity rate than women in the control group. A short puerperal convalescence was now validated by the official stamp of science.[42]

Not all physicians condoned early discharge, and then, as now, the issue drew the attention of the popular press. When Rotstein's study appeared in the *Journal of the American Medical Association*, *The New York Times* interviewed local obstetricians about their reactions. One insisted that Rotstein's protocol would never catch on in New York: "I would regard such a practice as antiphysiological."[43] In 1942, a perplexed physician from an area with a severe shortage of maternity beds wrote a letter to the *Journal of the American Medical Association* asking how long postpartum patients really needed to stay in bed. The editor responded that physicians should order a maximum confinement because women could not be trusted to exercise good judgment in caring for themselves. He granted that rules regarding the length of the puerperium were flexible, noting that in the 1910s the twilight sleep clinic in Germany had made a short convalescence fashionable for women who could have afforded a more leisurely hospital stay. He also observed, gratuitously, that "the average woman in that community looked like an old lady at forty."[44]

Nevertheless, hospitals hardest hit by the baby boom were discharging mothers as fast as they could. One writer joked that these maternity facilities should sport military industry's "E" symbol for "war production exceeding anticipated quotas."[45] At Elkhart General Hospital in Indiana, 55% of maternity patients were sent home within 24 hours of delivery. The head nurse, referring to the practice of sending mothers discharged early home by ambulance, remarked, "Our hospital is too small to accept the increasing number of maternity cases for the usual period. We could use another 100 beds if we had them. On the other hand, our town has six ambulances, well-heated and comfortable."[46] Hospitals in Washington, DC, also reduced postpartum stays to 1 day, thereby expanding their maternity facilities' capacity by 20% to 25%.[47] In the naval boomtown of Bremerton, Wash, crowded conditions prompted mothers to institute early discharge for themselves. With maternity beds piling up in the corridors, patients of a few days' standing reportedly volunteered, "I feel well enough to go home. Why can't I, so that that poor girl may have my bed?"[48] A 1944 issue of *Parents* magazine featured the story of one father whose wife was discharged from the hospital 1 hour after delivery. The man wrote, "It has been a lot of trouble," but that thanks to careful planning, they were managing.[49]

Coping With Early Discharge

No one denied that early discharge was stressful for new families. But during World War II, no legislation was proposed to enforce minimum lengths of stay for postpartum women. Instead, popular ideas about motherhood were revised and practical services were established to support mothers going home early.

In the American press, there was a campaign to boost the confidence of mothers discharged early. This campaign represented a significant reversal from what mothers had been told for the previous 2 decades. In the 1920s and 1930s, hospitals marketing themselves to prospective clients invoked the name of Science. Science implied that the authority and legitimacy of the hospital rested on knowledge far beyond the layperson's grasp; Science confirmed that the hospital knew what was best for mothers and babies.[50] An article in a 1939 issue of *Hygeia*, a lay health magazine published by the American Medical Association, typified this perspective. Bearing the caption "Your precious 'president' is protected and cared for here with scientific expertise," the article described a common scene on the postpartum unit: A mother hears her baby crying in the nursery. She is panic-stricken, imagining the worst. No need to worry, *Hygeia* assured its readers. Nursery nurses did not just hear babies cry; they were "experienced in judging infant vocalization." The article advised new mothers to leave the care of their infants to scientific professionals and invest their energy in something that was within their intellectual grasp, such as daydreaming about their baby's future presidential candidacy.[51]

Four years later, the picture had changed, and the "science" of motherhood was demystified. Under wartime conditions, just as women suddenly had what it took to be welders and riveters, they were now, it seemed, capable of being mothers. An arti-

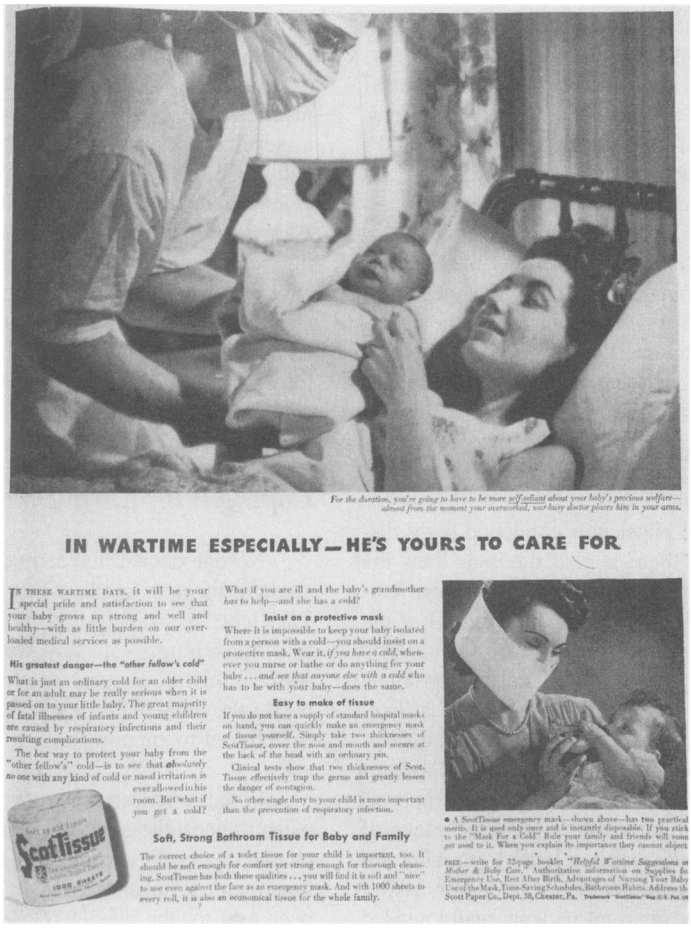


FIGURE 4—Self-reliance. From *Ladies' Home Journal*, November 1943, 85. Reprinted with permission of Kimberly-Clark Tissue Company.

cle in *American Home* featured a photograph of a confident, smiling mother holding her confident, smiling baby. The caption read, "Are babies people? They surely are, and they're nothing to be afraid of!" The article admonished mothers that it was no longer necessary or acceptable to look to experts for help. To bother overworked physicians with trivial questions about child care was "not only ridiculous but downright unpatriotic."[52]

A series of advertisements also assured women that they could handle a shortened maternity stay—with the help of ScotTissue paper. One ad with the headline "In Wartime Especially—He's Yours to Care For" featured a mother receiving her baby in a maternity ward (Figure 4). The ad read, "For the duration, you're going to have to be more self-reliant about your baby's precious welfare—almost from the moment your overworked, war-busy doctor places him in your arms." The ads recommended a perfect way for self-reliant mothers to protect their infants from respiratory infections: family members caring for the baby were to wrap 2 thicknesses of ScotTissue around their mouth and nose and clasp it in the back with a safety pin. In the wartime crunch, hospitals no longer had a monopoly on science: women could reproduce the scientific environment with a few handy household items.

While the press reassured mothers that they could cope on their own, mothers discharged early could also count on assistance from community-based health care agencies. The availability of visiting nurses for postpartum patients expanded significantly. Recognizing that families would need to augment hospitals' dwindling services, visiting nurse agencies began advertising directly to consumers. In 1942, for example, the San Francisco Visiting Nurse Association sent a postcard to all fathers of infants whose births were reported in the city's newspapers. Offering "a nurse for the price of a dozen roses," the postcard urged fathers to help themselves and their wives "overcome that helpless feeling" by paying $1.50 to be instructed in infant care skills at home. The offer was irresistible, and the Visiting Nurse Association reported that its postpartum program "increased by leaps and bounds."[53]

Mothers eligible for EMIC did not need to expend even $1.50 for home care. EMIC covered the cost of a postpartum visiting nurse for 6 visits if mother and baby were healthy and 14 visits if either was sick.[54] Agencies were eager to make it simple for EMIC mothers to obtain these services. For example, the Instructive Visiting Nurse Association, which coordinated home care for EMIC in Baltimore, arranged for hospitals to report all EMIC patients to the association on the day of their discharge home. A nurse from the association explained, "The patient and her family or friends, of course, had our telephone number, but numbers get lost, families become confused and we did not want to miss a single one."[55] Such zeal for ensuring the accessibility of care typified the EMIC program, which defined "quality of care" as "all community resources be[ing] mobilized to meet social as well as medical needs."[56]

A second form of community-based care was proposed to ease the stress of early discharge: postpartum convalescent homes. Popular in England, postnatal homes served as a waystation for new mothers between early discharge from a crowded hospital and return to an empty home. As Martha Eliot explained in *Ladies' Home Journal*, postnatal homes were a perfect wartime solution because they required no new construction but could be fashioned out of vacated houses or office buildings. Located near hospitals, they would offer the benefits of close medical supervision without the risks of overcrowded hospitals (particularly the risk of infectious diarrhea, which was becoming epidemic in many newborn nurseries).[57]

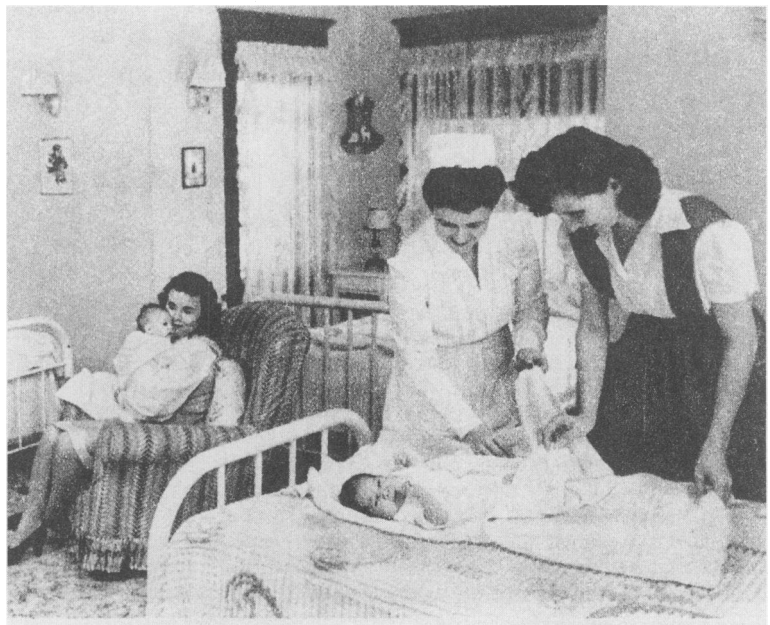
Postnatal homes did not catch on to the degree that Eliot had hoped, but there are a few accounts of successful ventures. Near Seattle, the Navy Post-Natal Convalescent Home opened in 1945 to provide care for sailors' wives after they left the hospital. The home was sponsored by the Navy Relief and the Naval Officers' Wives Club in recognition of the fact that uprooted storkers faced the challenges of caring for a new baby without the help of their husbands and families. The cost for mother and infant was $3 a day, toward which the Officers' Wives Club chipped in $0.50.[58] In Glendale, Calif, the Service Wives and Babies Home provided prenatal and postpartum care to the storkers who followed their husbands to the Glendale naval base. The home, which had originally been a dormitory for war workers, could accommodate 50 mothers and their babies. A nurse was on site to supervise mothers'

recovery and offer guidance on infant care (Figure 5). Residents lived communally, sharing meals and housework. Mothers paid $35 a month if they were from Glendale, $65 if they were not. When townspeople complained that the home should accept only local mothers, one of the home's founders gave this inspiring response: "Glendale girls are now in Florida and New Jersey and we pray that somebody there is taking care of them. Besides, our boys aren't fighting just for Glendale. They're fighting for something much bigger. And perhaps they like to know that we are too."[59]

Another program developed during the war to compensate for shortened maternity stays was prenatal education. Unlike the prenatal classes designed to prepare women for natural childbirth, which first appeared in the late 1940s, wartime classes focused on teaching women the parenting skills they would not have time to learn in the hospital. In New York City, the Henry Street Settlement sponsored "mothers' clubs." Free to servicemen's wives, mothers' clubs met weekly for lectures and demonstrations on preparing for and caring for infants.[60] In the military town of Fort Sill, Okla, the health department offered classes to storkers in collaboration with the United Service Organizations (USO). The program instructed expectant mothers in the care of themselves and their babies (Figure 6) and provided a social network for women separated from their family and friends. African American women in Fort Sill could attend classes sponsored by "the colored USO" and "taught by the Negro nurse of the county."[61]

The new mothers' networks facilitated formally by prenatal classes and informally by storkers' shared life circumstances in military communities also helped ease the burdens of early discharge. Although wartime mothers solidified the 20th-century trend toward going to the hospital to give birth, after delivery they recreated the 19th-century practice of social childbirth,[62] relying on their female neighbors to uphold this system of mutual support. As the director of activities at the York, Neb, USO advised pregnant women facing early discharge, "Get together with another girl or girls in similar plight and plan to help each other out. . . . Suggest to her that she come in a few hours a day and help you when you first get home from the hospital, and you will do the same when her turn comes. The pioneer women used to help each other. You young mothers today are pioneering, too."[63]

A sense of obligation to assist postpartum mothers extended beyond the camp towns. In New York City, Hazel Corbin of the Maternity Center Association had this suggestion for pregnant wives of servicemen: "I tell them to visit a neighborhood grocer and explain how helpless they'll be once the baby arrives. I've never yet heard of a storekeeper who didn't bend over backward to deliver food to these women even though he had a no-delivery policy."[64] Even grocers understood that shortened hospital stays after delivery made it the community's responsibility to deliver assistance to postpartum women.



Maternity ward—a first-floor corner room, once bachelors' dormitory for war workers. Visiting nurse, Jean LeGore, takes charge one day a week, relieving resident nurse. Chief entertainment is caring for the babies and listening to the radio.

FIGURE 5—The Glendale Service Wives and Babies Home. From "Born in Glendale," *Woman's Home Companion*, June 1944, 24.

Conclusion

While many mothers during World War II faced hospital stays as brief as those recently designated "drive-through deliveries" (and banned by Pub L No. 104-204), community services and community cohesion offset the strain. A public commitment to helping new mothers was facilitated by wartime ideology, in which health and public welfare measures could be recast in nationalistic terms.

It is interesting to note that in the literature justifying EMIC's generous and highly organized services for mothers and babies, the health of mothers and babies was rarely mentioned. Rather, EMIC was portrayed as a program to benefit husbands and fathers. The Children's Bureau explained, "The primary purpose of the EMIC program was to raise the morale of enlisted men by relieving them of concern over the uncertainty of the availability of maternity care for their wives and medical and hospital care for their infants, and of anxiety as to how the cost of this care would be met."[65] Katharine Lenroot, chief of the Children's Bureau, also described EMIC as a men's health initiative: "There is one casualty which no responsible nation should ask a fighting man to face. That casualty is the preventable injury of his wife or child back home."[66] Even high morale among enlisted fathers was not the true end point of EMIC. As one colonel remarked in support of EMIC, "A soldier worried about his family is not a good soldier."[67] Ultimately, good postpartum care was justified as a direct link to improved American military capabilities. While this fact does not negate the value and virtue of EMIC services for new mothers, it does suggest that social policy to enhance maternal–child health may be most successful when it is framed in other terms.

Wartime conditions enhanced the acceptability of public welfare measures that in peacetime would have been rejected as

FIGURE 6—Storkers in Fort Sill, Okla, learn about breakfast. From L. Sheddan and H. M. Culp, "Mother's Classes for Service Men's Wives," *Public Health Nursing* 36 (1944), 98. Reprinted with permission of Blackwell Science, Inc.

uncomfortably close to socialism. Congress stressed that maternity services under EMIC were not a "charity" but a "right."[68] Among physicians, anxiety over socialized medicine was tempered by a sense of patriotic duty. Many physicians regarded EMIC suspiciously as a "trial balloon for [the] complete federalization of medical practice."[69] In particular, the American Medical Association opposed EMIC's capping of fees for maternity cases at $50 and lobbied for a system of cash payments directly to mothers to replace the "third party bogie" (either state health agencies or the Children's Bureau) that disrupted a doctor's ability to negotiate fees with a patient.[70] Yet even in districts whose medical societies had voted to refuse EMIC patients, patriotism won out—temporarily. One reporter remarked, "Many doctors who cheerfully accept EMIC because there's a war on, would kick mightily if anyone attempted to extend it after the war."[71] While the exemplary outcomes for EMIC mothers and babies inspired talk of a civilian program of universal coverage for maternal–child health care, no such plan materialized.[72] The EMIC program was terminated in 1949, when the babies of the last fathers discharged from the service were 1 year old.

If the exceptional commitment to postpartum care seen during World War II was uniquely tied to the rhetoric of war, what lessons can we learn from that experience? During the war, maternal health advocates capitalized on political concerns to improve health care. In contrast, proponents of the recent drive-through delivery legislation capitalized on health care concerns to improve politics. Mothers and babies have always had enormous political appeal. As one observer commented, "[P]oliticians have found middle-class women and their children 'telegenic and sympathetic' in a way that allows this issue to serve as a surrogate for more pervasive (and dangerous) problems with market-driven medicine."[73] Although Public Law 104-204 may have benefited politicians, it is questionable how much it benefits mothers. President Clinton asserted that the law would "guarantee mothers the quality care they need," but the law does not address quality, only quantity.[74]

The World War II experience suggests alternatives to extending inpatient postpartum care. The wartime model of visiting nursing care might be an especially viable solution now. It is significant that today's drive-through deliveries evolved out of experimental programs combining early discharge with postpartum home visits. In the 1970s and early 1980s, hospitals offered early discharge to meet consumer demands for a more "natural" birth experience. In 1976, for example, Kaiser Permanente in San Francisco began an optional Family Centered Perinatal Care Program that involved discharge 12 hours after delivery and 4 home visits by a perinatal nurse practitioner. Similarly, in 1979, the University of California Davis Medical Center established the Homestyle Delivery Program, with discharge 6 to 24 hours after delivery and 2 home visits by a nurse practitioner[75]; in the mid-1980s, when the prospective payment system made early discharge an insurance-driven mandate rather than a consumer-driven option, the home visit portion of the short-stay package was dropped. Now, in a climate of market-driven medicine, and without a powerful political motivator such as war, the challenge is to restore maternal–child health to a priority status that will foster the regrowth of diverse, creative postpartum services. □

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Endnotes

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